JAMES F. BATTAGLIA, PH.D.
360 W 43rd Street, Apt. S9E
New York, NY 10036
646-455-3377

Dear Patient,

This download contains the following forms:

I. Informed Consent
II. Intake Form
III. HIPAA
IV. Health Insurance Claim Form
V. Cancellation Agreement

You can send me a completed digital copy to dr.jb.psychologist@gmail.com.

Special instructions for Form IV, Health Insurance Claim Form.

1. Please complete the boxes with check marks

If you have any questions about this, please ask me when we meet online.

James F. Battaglia, Ph.D.
Psychologist
NYL 012304

Form I - Informed Consent for Treatment

PATIENT: RETAIN THIS PAGE FOR YOUR RECORDS

JAMES F. BATTAGLIA, PH.D.
360 W 43rd Street, Apt. S9E
New York, NY 10036
646-455-3377
docjb.com

James F. Battaglia, Ph.D.
Psychologist
NYL: 012304 NJL: 3531

INFORMED CONSENT FOR TREATMENT 2025

Welcome to my psychology practice! I am looking forward to working with you and I willmake every effort to accommodate your needs. So that you may be fully informed about the services you are receiving, please take the time to read the following information about our practice policies. **Please do not hesitate to ask any questions if any of the following seems unclear.**

I would like you to be aware of your right to confidentiality and our commitment to safeguard that right. The patient-therapist relationship is a confidential and privileged one, and is thus protected by law and ethical code. However, there may be limits to confidentiality depending on your particular circumstance. For example, if your health care carrier is under the Federal ERISA act, it is entitled to and may request information about your sessions. Likewise, PIP, Workers' Compensation, and other legal/court cases may override confidentiality. In cases in which there is a clear risk of harm to self or others or of suspected child abuse, confidentiality is limited by law.

If you choose to engage in individual or group psychotherapy, please be aware that the process of psychotherapy involves change and can be an exciting process. At times, it may also seem frustrating and may arouse strong, difficult emotions. You may discover that the way you think about the world, the way you view your past, present, and future, and the way you relate to others may be altered. Therapy will require your work and commitment. My most important mission as a therapist is to help you make progress in your work toward reaching your goals. I will strive at all times to utilize my best clinical skills and professional judgment in this endeavor. In my work with children, please be mindful that parents/guardians should understand the need of their children to develop trust in a therapist. *Thus, I ask that parents/guardians limit their desire for specific details of the treatment.* However, I will be sure to address any concerns parents may have regarding their child's treatment.

PATIENT: RETAIN THIS PAGE FOR YOUR RECORDS

Individual and family therapy sessions are usually scheduled to last 45 minutes, unless otherwise indicated. Group therapy sessions last 90 minutes. I will make every effort to begin your session on time and I appreciate your timeliness in keeping appointments. The frequency of therapy sessions is arranged by you and me, based on recommendations and your needs. You are free to terminate therapy at any time. Typically, termination is usually a mutual goal that is planned for by the patient and therapist. If at any time you feel that therapy is not meeting your needs, you are strongly encouraged to present your concerns to me.

Regarding billing, payment in full is due at the time the service is rendered. Information regarding fees is available upon request. I reserve the right to charge an interest charge of 1 ½% per month (18% per annual percentage rate) on accounts that are greater than 30 days overdue. There is also a returned check fee of $25.00. Please note that in cases in which the account has been neglected by the patient and there has been no show of good faith despite our repeated attempts toward resolution, I reserve the right to turn the account over to a collection agency. In hardship circumstances, I am available to discuss payment arrangements.

If there is a matter that cannot wait until the next session, I am available by telephone at times other than your scheduled appointment. For a telephone call which lasts fifteen minutes or longer, I reserve the right to charge you a fee proportionate to the individual psychotherapy rate. If you have an emergency, and you call after regular business hours or cannot reach me, please call 991 or immediately go the emergency room of the nearest hospital.

I reserve the right to charge you for any missed appointments, or appointments that are canceled with less than 24 hours notice. I will not charge you if a health or family emergency arises. If an appointment is missed or canceled, I will reschedule you, hopefully during the same week.

I am an in-network provider for Aetna, United Healthcare, Oxford and Cigna.

NOTE: Patients in those plans must meet the deductible before the provider begins payment to me. So, you are responsible for paying for services until deductible is met. Please check your plan!

For patients not with those health plans, you are responsible for paying the full fee. *I encourage you to understand your plan's "out of network benefits," if any*. Unfortunately, I have learned that what your insurance provider/representative says over the phone is not always correct or clear. Ultimately, payment is your responsibility. I will assist you with the information you need to submit bills to your carrier. In some instances, I can bill electronically which will save you a step and get you reimbursed more quickly.

As of March 2020, I only offer sessions online with some exceptions. If you want more information, please ask!

PATIENT: COMPLETE THIS PAGE AND GIVE IT TO DR. BATTAGLIA

JAMES F. BATTAGLIA, PH.D.
360 W 43rd Street, Apt. S9E New York, NY 10036
646-455-3377

I have read and understood the Consent for Treatment 2025 provided me by Dr. Battaglia**.** By signing below, I request services from Dr. Battaglia and agree to the provisions of the Consent for Treatment.

_____
Print Patient Name

_____ Date: _____
Signature of Patient if age 14 or over

_____ Date: _____
Signature of Parent or Sole Legal Guardian
if Patient is under 18 years of age

_____
Signature of Other Parent if joint custody of Minor

I am a patient with (check one):

___United Healthcare (I am responsible for full payment until deductible, if any, is met.)

___Oxford (I am responsible for full payment until deductible, if any, is met.)

___Aetna (I am responsible for full payment until deductible, if any, is met.)

___Cigna (I am responsible for full payment until deductibe, if any, is met.)

___Other Insurance Company: _____ (I am always responsible for full payment at time of service.)

___None (I am always responsible for full payment at time of service.)

(Please photograph your United Healthcare, Oxford, Cigna Aetna card and text it to me at 201-755-0767 or email it to me at dr.jb.psychologist@gmail.com. Also, please complete the following information.)

ID: _____

Group: _____

Insured's Name: _____

Insured's DOB: _____

Form II - Adult Intake Form

JAMES F. BATTAGLIA, PH.D.
360 W 43rd Street, Apt. S9E
New York, NY 10036

PATIENT INTAKE FORM 2025

Please fill in the information below and bring it with you to your first session.
Please note: information provided on this form is protected as confidential information.

Personal Information

Name:_____Date:_____

Parent/Legal Guardian (if under 18): _____

Address: _____

City _____

State:_____Zip_____

Cell/Work/Other Phone: _____

Email: _____

**Please note: Email correspondence is not considered to be a confidential medium of communication.*

DOB: _____ Age: _____

Marital Status:

□ Never Married □ Married

□ Divorced □ Separated

□ Have partner partner □ Don't have partner

Referred By (if any): _____

Emergency Contact Name: _____ Phone:_____
Relationship: _____

Reasons for Seeking Therapy _____

_____

History

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

□ No □ Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication?

□ Yes □ No If yes, please list medication and dose:

_____

_____

Have you ever been prescribed psychiatric medication?

□ Yes □ No If yes, please list medication and dose:

_____

_____

General and Mental Health Information

1. How would you rate your current physical health? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing

_____

How would you rate our current sleeping habits (Please circle one)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

_____

2. How many times per week do you generally exercise? _____

3. What types of exercise do you participate in?_____

4. Please list any difficulties you experience with your appetite or eating problems:

_____

_____

5. Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes

If yes, for approximately how long?_____

6. Are you currently experiencing anxiety, panics attacks or have any phobias? □ No □ Yes

If yes, when did you begin experiencing this? _____

Are you currently experiencing any chronic pain? □ No □ Yes

If yes, please describe: _____

7. Do you drink alcohol more than once a week? □ No □ Yes Times a week: _____

8. Do you use recreational drugs? □ No □ Yes

What? _____ How Often?_____

9. Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? _____

On a scale of 1-10 (with 1 being poor and 10 being exceptional), how would you rate your relationship?

1 2 3 4 5 6 7 8 9 10

What significant life changes or stressful events have you experienced recently?

_____

_____

Family Mental Health History

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (e.g. Father, grandmother, uncle, etc.)

	Please Circle	Identify Family Member
Alcohol/Substance Abuse	yes / no	_____
Anxiety	yes / no	_____
Depression	yes / no	_____
Domestic Violence	yes / no	_____
Eating Disorders	yes / no	_____
Obesity	yes / no	_____
Obsessive Compulsive Behavior	yes / no	_____
Schizophrenia	yes / no	_____
Suicide Attempts	yes / no	_____

Additional Information

1. Are you currently employed? □ No □ Yes

Where do you work? What is your job?

_____

_____

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief: _____

What do you consider to be some of your strengths?

_____

_____

3. What do you consider to be some of your weaknesses?

_____

_____

4. Have you been in psychotherapy before? □ No □ Yes

If yes, how long? _____

5. What would you like to accomplish out of your time in therapy? _

_____

_____

Form III - HIPAA Notice

JAMES F. BATTAGLIA, PH.D.
PSYCHOLOGIST
NEW YORK

Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information 2025

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

James F. Battaglia, Ph.D., hereafter referred to as "I," may *use* or *disclose* your *protected health information (PHI)*, for *treatment*, *payment*, and *health care operations* purposes with your consent. To help clarify these terms, here are some definitions:

- "*PHI*" refers to information in your health record that could identify you.

- "*Treatment, Payment and Health Care Operations*"
  - *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
  - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

- "*Use*" applies only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

- "*Disclosure*" applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization*" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization before releasing psychotherapy notes. "*Psychotherapy notes*" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If I have reasonable cause to believe that a child has been abused or neglected, I am required by law to report such information within 24 hours to the NYC Administration for Children's Services.
-
- **Adult and Domestic Abuse:** If I have reasonable cause to believe that an elderly or disabled adult has been abused, neglected, or exploited, I am required by law to report this information to the county adult protective services provider .

- **Health Oversight:** If the New York State Board of Psychological Examiners issues a subpoena, I may be compelled to testify before the Board and produce your relevant records and papers.

- **Judicial or administrative proceedings:** If you are involved in a court proceeding and a request is made for information about the professional services that I have provided you and/or the records thereof, such information is privileged under state law, and I must not release this information without written authorization from you or your legally appointed representative, or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. I will inform you in advance if this is the case.

- **Serious Threat to Health or Safety:** If you communicate to me a threat of imminent serious physical violence against yourself or a readily identifiable victim and I believe you intend to carry out that threat, I must take steps to warn and protect. I also must take such steps if I believe you intend to carry out such violence, even if you have not made a specific verbal threat. The steps I take to warn and protect may include arranging for you to be admitted to a psychiatric unit of a hospital or other health care facility, advising the police of your threat and the identity of the intended victim, warning the intended victim or his or her parents if the intended victim is under 18, and warning your parents if you are under 18.

- **Worker's Compensation:** If you file a worker's compensation claim, I may be required to release relevant information from your mental health records to a participant in the worker's compensation case, a reinsurer, the health care provider, medical and non-medical experts in connection with the case, the Division of Worker's Compensation or the Compensation Rating and Inspection Bureau.

IV. Patient's Rights and Psychologists Duties

Patient's Rights:

- *Right to Request Restrictions* - You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.

- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* - You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)

- *Right to Inspect and Copy* - You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

- *Right to Amend* - You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request I will discuss with you the details of the amendment process.

- *Right to an Accounting* - You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice.) On your request, I will discuss with you the details of the accounting process.

- *Right to a Paper Copy* - You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

- If I revise my policies and procedures, I will notify you in person or by mail.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact me, James Battaglia at 646-45-3377

If you believe that your privacy rights have been violated and wish to file a complaint with me, please contact:

New York's Professional Misconduct Enforcement System
Complaint Hot Line:
1-800-442-8106 or conduct@mail.nysed.gov

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date

This notice has gone into effect on the date signed.

Your signature on the signature page acknowledges that you have read and understood the information in this document and agree to abide by its terms during our professional relationship.

Acknowledgement of Receipt of HIPAA Notice 2025

By your signature below, you indicate that you have received a copy of the "Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information" from James F. Battaglia, Ph.D.

_____ _____
Signature of Patient if 14 years or older Date

_____ _____
Print your name above Birthdate

_____
Signature of Parent/Guardian if pt. is under 18 years

_____
Signature of other Parent/Guardian if Joint Custody

Form IV - Health Insurance Claim Form

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

1. MEDICARE | MEDICAID | TRICARE | CHAMPVA | GROUP HEALTH PLAN | FECA BLK LUNG | OTHER
(Member ID#) | (ID#) | (ID#) | (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED
Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code)

( )

ZIP CODE | TELEPHONE (Include Area Code)

( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous)
YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State)
YES | NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT?
YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
YES | NO *If yes*, complete items 9, 9a, and 9d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts as signment below.

XSIGNED

DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY
QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY
FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY
FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? $ CHARGES
YES | NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back)
YES | NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd. for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

Form V - Cancellation Policy

JAMES F. BATTAGLIA, PH.D

360 W 43rd Street, Apt. S9E
New York, NY 10036
646-455-3377

CANCELLATION POLICY 2025

I understand the following office policy regarding cancellation or failing to attend a scheduled appointment:

1) When cancelling an appointment, I must give more than 48 hours notice. I understand there are exceptions, including illness and emergencies.
   a. If a cancellation is made less than 48 hours before the scheduled appointment, the reserved time may be forfeited and I may be placed on the waiting list until another time slot opens.
   b. If two appointments are canceled without giving 48 hours notice, the reserved time may be forfeited and I may be referred to another provider.

2) I understand my credit card information is to be kept on file with Dr. Battaglia in a secure place. If an appointment is cancelled without the 48 hour prior notice, Dr. Battaglia will take that as consent to charge the session fee to credit card. Therefore, I have provided my credit card information below along with my consent that the missed session's fee be charged to the card.

3) I understand that when a cancellation is made within the required time frame, Dr. Battaglia will do his best to reschedule me for the same week. I am aware that this may not be possible.

4) When canceling or rescheduling an appointment, I agree to contact Dr. Battaglia by text at 201-755-0767 or email me at dr.jb.psychologist@gmail.com .

I agree to the above.

Signed: _____

Date: _____

_____

Please Print:

Name on Credit Card: _____

Credit Card Number: _____

Expiration Date: _____ CVV Code: _____